Bureau of Health Care Quality & Compliance

Accepted POC 7/15/09 DBoyle

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN205AGC	A. BUILDING _____ B. WING _____	04/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY GROUP CARE	2690 MARGARET DR RENO, NV 89506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted on your facility 3/31/09-4/3/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received an annual survey grade of D. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was six. Six resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified:	Y 000		
Y 026 SS=F	449.190(3) Contents of License-Multiple Types NAC 449.190 3. A residential facility may be licensed as more than one type of residential facility if the facility provides evidence satisfactory to the bureau that it complies with the requirements for each type of facility and can demonstrate that the residents will be protected and receive necessary care and services. This Regulation is not met as evidenced by:	Y 026	RECEIVED [illegible] AND CERTIFICATION CARSON CITY, NEVADA	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4-20-09

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Y 026	Continued From page 1 Based on observation, record review and interview on 3/31/09, the facility was caring for 1 of 6 persons with mental illnesses without a mental illness endorsement on its license and failed to ensure 2 of 2 caregivers had obtained the necessary training to care for such persons. Severity: 2 Scope: 3	Y 026	The 2 of the 2 caregiver will obtain the necessary training for mental illness when there is resident when there is one available. FAX it or mail it. Verified during visit that Emp. #1 was removed to St. Paul's HC on 4/30/09 DB	
Y 070 SS=E	449.196(1)(f) Qualifications of Caregiver-8 hours training NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. This Regulation is not met as evidenced by: Based on record review on 3/31/09, the facility failed to ensure that 1 of 2 caregivers received eight hours of annual training (Employee #2). Severity: 2 Scope: 2	Y 070	The caregiver # 2 has more than 8 hrs, training, but she forgot to make copies for the caregiver file. Enclose copies. DB 5/6	
Y 178 SS=F	449.209(5) Health and Sanitation-Maintain Int/Ext NAC 449.209 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained.	Y 178		

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Y 178	Continued From page 2 This Regulation is not met as evidenced by: Based on observation and interview on 3/31/09, the handle on the sliding glass door that leads to the back patio was missing, the flushing handle on the toilet in the second hall bathroom was broken, the door to the first hallway door would not close completely, and scrap wood was left in a pile in the back yard. Severity: 2 Scope: 3	Y 178	The facilities glass doors are already been fixed & the bathroom broken handle, also, the door knob of the bathroom. The scrap wood pile in the back yard will be pick up on 4-02-09. OK DB	
Y 181 SS=F	449.209(8) Health and Sanitation-Temperature NAC 449.209 8. The temperature of the facility must be maintained at a level that is not less than 68 degrees Fahrenheit and not more than 82 degrees Fahrenheit. This Regulation is not met as evidenced by: Based on observation and interview on 3/31/08, the interior temperature of the facility was 66 degrees and the house was not maintained at the minimum temperature of 68 degrees for 6 of 6 residents (Resident #1, #2, #3, #4, #5 and #6). Severity: 2 Scope: 3	Y 181	The facility's temp. has been monitored & maintain at a minimum temp of 68-70 degrees. OK DB for the residents at house 4/4/09 and temperature was completed	
Y 431 SS=C	449.229(2)(a)-(c) Plans for Evacuation NAC 449.229 2. A residential facility shall have a plan for the evacuation of resident in case of fire or other emergency. The plan must be:	Y 431		

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Y 431	Continued From page 3 (a) Understood by all employees. (b) Posted in a common area of the facility. (c) Discussed with each resident at the time of his admission. This Regulation is not met as evidenced by: Based on observation on 3/31/09, the administrator failed to ensure the evacuation plans posted throughout the facility were current and reflected layout of the remodeled facility. Severity: 1 Scope: 3	Y 431	The facility already made a new evacuation plan and posted at every effected area. enclosed copy -	04/03
Y 530 SS=E	449.260(1)(e) Activities for Residents NAC 449.260 (e) Provide for the residents at least 10 hours each week of scheduled activities that are suited to their interests and capacities. This Regulation is not met as evidenced by: Based on observation and interview on 3/31/09-4/3/09, the administrator did not provide activities for residents beyond basic activities of daily living, smoking or watching TV. Severity: 2 Scope: 2	Y 530	The facility will encourage every single resident to do activities that suited them on their own interest & capabilities. New Activities Schedules Provided for review on 7/9/09	

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Y 843	Continued From page 4	Y 843		
Y 843 SS=I	449.2738(3) Review of medical condition of a resident NAC 449.2738 3. If an inspection or investigation reveals that the conditions at a residential facility may immediately jeopardize the health and safety of a resident, the administrator of the facility shall, as soon as practicable, ensure that the resident is transferred to a facility which is capable of properly providing for his care. This Regulation is not met as evidenced by: Based on observation, interview and record review on 3/31/09, the administrator admitted a resident with a mental illness history that threatened the safety of the other five residents (Resident #2, #3, #4, #5 and #6). Findings include: During the annual survey on 3/31/09 at approximately 10:30 AM, Resident #2 wheeled herself out of her bedroom to the kitchen to voice a complaint about Resident #1 to the administrator, Employee #1. Resident #2 was interviewed in her room and she reported she was resting in her bed when she heard her door open. She stated she pretended to be asleep but observed Resident #1 open the drawer in her bedside table and take out a pack of cigarettes. Resident #1 stated she did not confront Resident #1 and pretended to be asleep because Resident #1 "is crazy." The administrator reported she asked Resident #1 where she got her cigarettes	Y 843	The resident w/ mental illness will be moving to a facility w/ a mental illness license on the 30th of this month. DC DB	

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Y 843	Continued From page 5 and the resident admitted she took them from Resident #2's room. At 10:45 AM, Resident #1 wheeled herself in a wheelchair from her bedroom on the east side of the house, through the kitchen on her way to the enclosed back patio to smoke a cigarette. The resident was speaking loudly to no-one in particular about the government and how they were out to get everyone, communism, etc. She was using the F-word and was told by the administrator not to use curse words. The resident wheeled herself to the patio to smoke. Later in the survey, Resident #1 wheeled herself to resident rooms on the west side of the house and viewed Resident #4 in her room. Resident #1 came back down the hall yelling that Resident #4 was in serious medical trouble because of the purple color under her eyes; that the resident needed immediate medical care; about Chinese remedies and other concerns. The administrator had to re-direct the resident as her outburst was disturbing other residents. Review of the facility file for Resident #1 revealed the resident was a 61-year old female with a history of schizoaffective disorder and bipolar disorder. The resident is a Washoe County Public Guardian's office client. Prior to her admission to the facility, the resident was homeless and was arrested for trespassing. The resident was placed in the Washoe County jail and the jail initialed a "Legal 2000" due to the resident's rambling, non-sensical answers to questions and a lack of self care. The resident was transferred to Renown hospital and then to Northern Nevada Adult Mental Health Services' (NNAMHS) acute psychiatric ward. During a 12/16/08 psychiatric evaluation,	Y 843		

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Y 843	Continued From page 6 Resident #1 claimed her real name was Nadia Marx and the resident's name was just an alias. The evaluator indicated the resident's judgment, insight and impulse control were all severely impaired; the resident was easily agitated and oppositional in general; and clearly delusional. The 12/16/08 evaluation report also indicated Resident #1 had five previous admissions to NNAMHS and two admissions to Lakes Crossing, a secured psychiatric ward for evaluation of competency to go to trial. The resident had previous psychiatric admissions in Chicago and had also attempted suicide. The resident had been arrested numerous times for assault and battery with a deadly weapon; had misdemeanor charges for indecent exposure and trespassing and was sentenced to jail for three of the charges but was found to be too incompetent to stand trial. The 12/16/08 evaluation report revealed that in 2007, Resident #1 struck a group home manager with a glass coffee carafe after she became upset with the caregiver. The caregiver sustained injuries from this assault. It was revealed the resident also lived in another Reno group home but left the home on 10/28/08. The resident was living on the streets and was taken to a women's drop-in shelter because she refused to return to the group home. The resident was then kicked out of the shelter due to her behaviors. Resident #1 has been prescribed numerous psychotropic medications over the years including Depakote, Risperdal, Lithium, Zyprexa, Haldol, Seroquel, Geodon and Abilify. The resident was currently prescribed the anti-psychotic medication Zyprexa. Resident #1 was admitted to this group home on	Y 843		

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Y 843	Continued From page 7 2/4/09. The facility does not have a mental illness endorsement as part of their license from the Bureau. The administrator was questioned about her knowledge of the resident's mental illness diagnoses and her history of assaulting caregivers. The administrator stated she did not read the psychiatric evaluation and did not know about the resident's history. She reported the resident did try to leave the facility after she was caught smoking in her room and was told she would have to smoke on the patio. Resident #1's public guardian was called by the surveyor to discuss her placement in the facility. The guardian reported she was not aware the facility required a special endorsement to care for mentally ill residents. She stated the administrator saw the resident prior to admission and reported she could admit the resident. The guardian reported the resident was doing well at the facility and said she liked it there, and that she had not been told of any problems being created by the resident. The guardian reported she would begin the process of finding appropriate placement for the resident but stated she has had difficulty in the past with placing the resident in group homes. Severity: 3 Scope: 3	Y 843		
Y 878 SS=G	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be	Y 878		

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Y 878	Continued From page 8 administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on interview and record review on 3/31/09-4/3/09, the administrator failed to ensure 1 of 6 residents received their medications as prescribed (Resident #2). Findings include: Resident #2 was admitted to the facility on 1/7/07. The resident's diagnoses include high blood pressure, depression, esophagitis, chronic pain and seizure disorder. The resident was prescribed Morphine 30 mg, two times a day. The medication was listed on the resident's medication administration records (MARs) back to July of 2008. Resident #2's March 2009 MAR showed the resident stopped receiving the Morphine on 3/13/09. The administrator reported the facility ran out of the medication and that the resident's doctor did not write a prescription to re-fill the medication. There was no physician's order to discontinue the Morphine. The administrator was asked if she contacted the resident's physician concerning the missed Morphine doses. The administrator reported she took the resident to see her doctor on 3/12/09. The administrator stated she wrote the resident's medications on a medication review form and presented it to the doctor. It was pointed out to the administrator	Y 878	The resident did not miss any of his morphine because, Morphine + MS contin 30 mg is the same enclose copy: 3/2009 MAR shows N/A given 3/13/09 → 4/3/09 – Med. Rilled on 4/2/09 – 7/9/09 - See Attachments. DHS	

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Y 878	Continued From page 9 that Morphine was not included on the list of medications and she reported she forgot to write the Morphine on the list. Resident #2's doctor wrote on the medication review form that there were "no changes" to the resident's medication regimen, then signed and dated the form on 3/12/09. The administrator reported she did not mention to the resident's physician that the resident had only one more day of the medication left and that a new prescription was needed. She reported the physician also did not notice the Morphine was missing from the list of medications. The administrator reported the resident had not asked her about the Morphine pills so the administrator thought the resident was doing fine without the medication. Resident #2 was interviewed in her room. The resident reported she has chronic pain and always hurts. The resident did not indicate she was aware that she was no longer receiving one of her pain medications. Resident #2's case worker reported on 4/3/09 that he was not aware the resident had not been receiving her Morphine. He stated he saw his resident on 4/2/09 concerning an incident with Resident #1 and the facility did not report to him that there was a problem with the medication. Severity: 3 Scope: 1	Y 878		
Y 883 SS=D	449.2742(7) Medication / Resident Refusal NAC 449.2742 7. If a resident refuses, or otherwise misses, and administration of medication, a physician must be notified within 12 hours after the dose is refused	Y 883		

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Y 883	Continued From page 10 or missed. This Regulation is not met as evidenced by: Based on interview and record review on 3/31/09, the administrator failed to ensure 1 of 6 resident physicians were notified within 12 hours after a dose of medication was missed. Severity: 2 Scope: 1	Y 883	The #2 resident Doctor has been notified as just a misunderstand that morphine 30 mg + Mrs Contin 30 mg are the same medication. enclosed Copy T/C w/ Admin 9/15/09 Discussed or rep to call physician of Resident misses meds.	

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